Spouse
Application for Admission
To the Iowa Veterans Home

1301 Summit Street - Marshalltown, Iowa 50158-5485
Telephone (641) 753-4325 or 800-645-4591

THIS APPLICATION MUST BE THOROUGHLY COMPLETED OR THE ADMISSION PROCESS MAY BE DELAYED. SUBMIT WITH APPLICATION A COPY OF YOUR SPOUSE'S HONORABLE DISCHARGE OR DD-214, MARRIAGE CERTIFICATE, AND DEATH CERTIFICATE (IF APPLICABLE).

A COPY OF A COMPLETE HISTORY AND PHYSICAL IS REQUIRED. THIS HISTORY AND PHYSICAL MUST BE DATED WITHIN THREE MONTHS FROM THE DATE THE IVH APPLICATION IS RECEIVED. YOUR HEALTH CARE PROVIDER MUST ALSO SUBMIT LAB WORK, IMMUNIZATIONS, YOUR HISTORY OF TESTING AND RESULTS OF RESISTANT ORGANISIMS (MRSA OR VRE), AND PPD (TB TESTING).

DATE/MONTH OF REQUESTED ADMISSION: _____

1. Applicant's name in full _____
   (Last) (First) (Middle) (Maiden)
2. Legal Residence _____
   (Address) (City) (Zip Code)

   County of residence _____ Present Address _____
   (If at facility skip to next line) (Address) (City) (Zip Code)

   Current facility _____ Admission date _____
   (Name) (Address)

   Main Phone Number _____ Facility Phone Number _____
3. Date of Birth _____ Birthplace _____
   (County) (City) (State)
4. Social Security Number _____ Spouse's Social Security Number _____
5. If foreign born, are you a U.S. citizen? _____ Naturalized? _____

   Date and place of Naturalization _____
6. Father's Name _____ Birthplace _____
   (First-Middle-Last) (County) (City) (State)
7. Mother's *Maiden* Name _____ Birthplace _____
   (First-Middle-Last) (County) (City) (State)
8. **MARRIAGES:** Provide the following information for **MOST RECENT** marriage. If applying under previous spouse, submit marriage information on that marriage and all subsequent marriages. Use separate sheet if necessary. Copies of all marriage, divorce and/or death certificates will be required.

   Circle one of the following: Married Widowed Divorced Separated

   Spouse's full name _____ Birthplace _____
   (First-Middle-Last) (County) (City) (State)

   Date of Birth _____ Date of Marriage _____ Place _____
   (Month/Day/Year) (Month/Day/Year) (City) (State)

   How marriage ended _____ When _____ Where _____
   (If applicable) (Month/Day/Year) (City) (State)

9. **CHILDREN:** Applicant _____

Please indicate approval to contact children regarding the application process by circling yes or no before each name.

YES/NO _____
Name Address, City, State, Zip Code

_____
Age Relationship Main Phone Alternate Phone Number (Work, Cell, Other)

YES/NO _____
Name Street, City, State, Zip Code

_____
Age Relationship Main Phone Alternate Phone Number (Work, Cell, Other)

YES/NO _____
Name Address, City, State, Zip Code

_____
Age Relationship Main Phone Alternate Phone Number (Work, Cell, Other)

Attach separate sheet for additional children. List all living children, regardless of age. If there are minors, furnish a copy of the birth certificates.

10. Your usual occupation _____ Kind of business or industry _____
Do NOT write retired

Spouse's usual occupation _____ Kind of business or industry _____
Do NOT write retired

11. Date you retired or became disabled _____ Date spouse retired or became disabled _____

If you receive Social Security, is it from your work? Yes ☐ No☐ Spouse's work? Yes ☐ No ☐

Your Civil Service Annuity Number _____ Railroad Retirement Number _____

Spouse's Civil Service Annuity Number _____ Railroad Retirement Number _____

Do you have Medicare? **Part A:** Yes ☐ No ☐ **Part B:** Yes ☐ No ☐ **Part D:** Yes ☐ No ☐

Medicare Number _____ Are you on Medicaid? Yes ☐ No ☐ Number _____

Do you have other health insurance? Yes ☐ No ☐ Name of company _____

Do you have Nursing Home insurance? Yes ☐ No ☐ Name of company _____

PROVIDE A COPY OF THE FRONT AND BACK OF MEDICARE AND OTHER INSURANCE CARDS

12. **EDUCATION:** (Circle highest level of completion)

Elementary: 1, 2, 3, 4, 5, 6, 7, 8 High School: 9, 10, 11, 12, GED College: 1, 2, 3, 4 AA, BA

13. **CIRCLE SPOUSE'S BRANCH OF SERVICE:** Army Navy Marines Air Force Coast Guard Merchant Marines WACS WAVES WAAF WMC SPARS Nurse Corps

Date of spouse's enlistment _____ Place _____

14. Unit number and name _____ Spouse's Rank at discharge _____

Date of Discharge _____ Place _____

15. Spouse's Armed Services Number _____ Spouse's DVA Claim or File Number _____

16. Number of year's residence in Iowa? _____

17. **LEGAL DECISION MAKERS: (Continued on page 3)**

a. Are you under court appointed Conservatorship? _____
(Please provide a copy) Name Main Phone Number

_____
Address City State Zip Code

b. Are you under court appointed Guardianship? _____
(Please provide a copy) Name Main Phone Number

_____
Address City State `Zip Code

Applicant _____

c. Financial Power of Attorney _____
(Please provide a copy) Name Main Phone Number

_____
Address City State Zip Code

s. Healthcare Power of Attorney _____
(Please provide a copy) Name Main Phone Number

_____
Address City State Zip code

18. Your religious preference (optional) _____
Denomination

19. Person to be notified in an emergency _____
(If more than one person, list on separate sheet and mark it no. 21) Name

_____
Address City State Zip Code

_____
Relationship Main Phone Number Alternate Phone Number (Work, Cell, Other)

20. Have you ever been a member of the Iowa Veterans Home? _____ Have you ever been a member of any other State Institution or State Veterans Home? _____ If so where? _____

When were you discharged? _____ Why were you discharged? _____

21. I desire to be buried in _____ Cemetery, located at _____

_____
County City State Zip Code

22. My funeral home of preference is _____
Name Telephone Number

_____
County City State Zip Code

24. Is there a prefunded funeral contract or burial trust? _____ (Please provide copy of contract or trust.)

APPLICANT OR LEGAL REPRESENTATIVE TO READ THE FOLLOWING AND SIGN:

I am applying for admission to the Iowa Veterans Home. I am a resident of the state of Iowa. All of the statements on this application are true and complete to the best of my knowledge. I hereby give permission to the Iowa Veterans Home to do a background check. If admitted, I understand that all income and assets, regardless of source, will be considered in the determination of my cost of care. I understand that all personal expenses and/or prior existing debts are my responsibility.

_____
Signature of Applicant or Legal Representative

CERTIFICATE OF COUNTY COMMISSION OF VETERAN AFFAIRS

We hereby certify that _____ has been a resident of _____ County, State of Iowa, prior to date of this application as provided for by Chapter 35D of the Code of Iowa, and that we are members of the County Commission of Veteran Affairs of said county.

STATE OF IOWA
COUNTY OF _____

COUNTY COMMISSION OF VETERANS AFFAIRS

Signed or attested before me on this day

_____
Month Day Year

By _____

_____
Notary Public in and for State of Iowa

1. _____

2. _____

HISTORY AND PHYSICAL COMPLETED BY M.D., D.O., P.A.-C, or N.P.
TYPE OR PRINT LEGIBLY

NAME _____ AGE _____ RACE _____

I. DIAGNOSIS (Must be shown)
- A. Current Primary Diagnosis _____
- B. Additional Diagnosis _____
- C. Current Medications _____
- D. Competent for Health Care Decisions _____ (yes or no)
- E. Competent for Financial Decisions _____ (yes or no)
- F. Is he/she court committed _____ (yes or no)
- G. Diet _____
- Type of commitment _____

II. BRIEF HISTORY
- A. Allergies _____
- B. Past Medical Hx _____
- C. Accidents _____
- D. Past Surgical Hx _____
- E. Hospitalizations in the past five years: (Attach additional pages if necessary.)

Name/Address of Hospital: Dates of Admission:

_____

_____

- F. History of testing/results of drug resistant organisms (i.e., MRSA, VRE) _____
- G. Immunization Records _____
- H. Hx PPD _____

III. SYMPTOMS [Include description of incapacity as a result of symptoms (use a separate page if necessary.)]
- A. GI Tract _____
- B. Respiratory _____
- C. Cardiovascular _____
- D. GU System _____
- E. Nervous System _____

IV. PHYSICAL FINDINGS
- A. Blood Pressure/Pulse _____ Height _____ Weight _____
- B. Head and Neck _____
- C. Eyes and Ears _____
- D. Nose and Throat _____
- E. Chest _____
- F. Abdomen _____
- G. Vagina _____ Current Pap Smear _____
- H. Extremities _____ Breast Exam _____
- I. Genitalia _____ Hernia _____
- J. Rectal Examination _____ Prostate _____

V. LABORATORY: Show all findings of laboratory tests and x-ray results.
- A. Urinalysis _____ CBC _____
- B. If diabetic--recent fasting blood sugar results _____ Date taken _____
- C. Report of chest x-rays--must be current or within last year _____ Date taken _____

PRINT OR TYPE NAME OF EXAMINING CARE PROVIDER: _____

Examining Care Provider signature (M.D, D.O., P.A.-C, N.P.): _____ **DATE:** _____

Address: _____
Street City State Zip Code

PLEASE ATTACH ANY ADDITIONAL PERTINENT MEDICAL INFORMATION